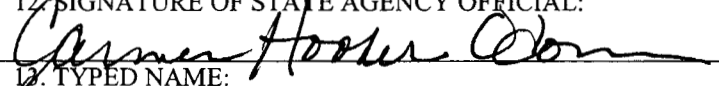



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 03-011	2. STATE NC
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE Effective May 1, 2003 <i>Oct 1, 03</i> <i>Pen + Ink Change per e-mail from SA</i>	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)		
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.201	7. FEDERAL BUDGET IMPACT: a. FFY 2004 \$0.00 b. FFY 2005 \$0.00	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Section 12, Page 3	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B, Section 12, Page 3	

10. SUBJECT OF AMENDMENT: Prosthetic and Orthotic Devices	
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Not Required <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL	

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Office of the Secretary Department of Health and Human Services 2001 Mail Service Center Raleigh, North Carolina 27699-2001
13. TYPED NAME: Carmen Hooker Odom	
14. TITLE: Secretary	
15. DATE SUBMITTED: 12/4/03	

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED: December 2, 2003	18. DATE APPROVED: December 2, 2003
19. PLAN APPROVED - ONE COPY ATTACHED	
20. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2003	21. SIGNATURE OF REGIONAL OFFICIAL: 
22. TYPED NAME: Samuel Murray	23. TITLE: Regional Administrator
24. REMARKS: Proposed effective date changed to May 1, 2003	

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in disease of the eye or by an optometrist.

12.c. PROSTHETIC AND ORTHOTIC DEVICES

Payment for each claim for prosthetic/orthotic devices will be equal to the lower of the supplier's usual and customary billed charges or the maximum fee established for each item. The maximum fees are set at 100 percent of the Medicare Part B fees as of January 1 of each year. If a Medicare fee cannot be obtained for a particular item, the fee will be based on estimates of reasonable costs and updated each January 1 by the forecasted percentage increase in prices for the devices. **Notwithstanding any other provision, if specified these rates will be adjusted as shown on Supplement 4 to the Attachment 4.19-B section of the state plan.** There will be no retroactive payment adjustments for fee changes.

When devices are provided by state or local government agencies, reimbursement will not exceed the cost of the device.